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ORIGINAL ARTICLE

Exploring experiences of and attitudes towards mental illness and disclosure amongst health care professionals: a qualitative study

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ABSTRACT

Background: The literature suggests that many health professionals hold stigmatising attitudes towards those with mental illness and that this impacts on patient care. Little attention has been given to how these attitudes affect colleagues with a mental illness. Current research demonstrates that stigma and discrimination are common in the UK workplace and impact on one's decision to disclose mental illness.

Aims: This study aims to explore health professionals' experiences of and attitudes towards mental illness and disclosure in the workplace.

Methods: This qualitative study involved semi-structured interviews with 24 health professionals employed by an NHS (National Health Service) trust. 13 of these worked in mental health, and 11 in other health fields. Interviews were transcribed and thematic analysis was used to identify themes.

Results: Five key themes were identified from the data: personal experiences and their effect in changing attitudes; perceived stigmatising views of mental illness in other staff members; hypothetical disclosure: factors affecting one's decision; attitudes towards disclosure; support in the workplace after disclosure; and, applying only to those working outside of the mental health field, mental illness is not talked about. The results indicated that participants had a great deal of experience with colleagues with a mental illness and that support in the workplace for such illnesses is variable. Attitudes of participating health professionals towards colleagues with a mental illness appeared to be positive, however, they did report that other colleagues held negative attitudes. Deciding to disclose a mental illness was a carefully thought out decision with a number of advantages and disadvantages noted. In particular, it was found that health professionals' fear stigma and discrimination from colleagues and that this would dissuade participants from disclosing a mental illness.

Conclusion: In many respects, this research supports the findings in other workplaces. Such findings need to be investigated further to identify the degree to which these experiences and attitudes can be applied to other health professionals in other healthcare settings to determine what intervention is necessary. Importantly, this study has also indicated that the level of support available to NHS health professionals with a mental illness is variable, suggesting the need to identify and replicate positive practice.

Keywords

Mental health, mental illness, stigma, disclosure, healthcare professionals

History

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Introduction

There is evidence that campaigns to improve public attitudes and understanding of mental illness have had positive effects (Evans-Lacko et al., 2014; Jorm et al., 1999). However, in the absence of such campaigns there is no evidence of such improvement (Schomerus et al., 2012), and mental illness

remains widely misunderstood to the detriment of those affected. Misconceptions surrounding mental illness create negative public attitudes (Angermeyer & Dietrich, 2006) resulting in stigmatisation of those with mental illness (Rüsch et al., 2005)—potentially 25% of British adults per year (Singleton et al., 2001). Over time this can lead to internalised “self-stigmatisation”—a damaging phenomenon amongst mental health service users (Corrigan et al., 2015a).

Health professionals are an important group as their attitudes towards mental illness can affect their patient care and their response to both their own and their colleagues' experiences of mental illness. Evidence shows that attitudes held by health professionals are similar to the general public (Lauber et al., 2004) or more negative (Nordt et al., 2006). One

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study (sample size 4485) comparing health professionals and members of the public found stigmatising attitudes towards patients (Jorm *et al.*, 1999), consistent with studies comparing health professional's attitudes towards physical illness and mental illness (Kakuma *et al.*, 2011; Minas *et al.*, 2011).

Such attitudes among health professionals can contribute to the stigmatisation of mental health service users. The Viewpoint survey found that health professionals are a frequent source of discrimination reported by those with mental illness (Corker *et al.*, 2013) and patients have reported: being treated with disrespect; longer waits than other patients; and the suspicion that physical complaints are imagined (Schulze & Angermeyer, 2003).

Recently, increasing attention has been paid to attitudes of healthcare staff towards mental illness and the implications for quality of care (Henderson *et al.*, 2014a). However, little attention has been given to health professionals' attitudes towards mental illness in colleagues or themselves. We found no research to identify attitudes towards colleagues with mental illness within the National Health Service (NHS), however some research conducted in Canada shows stigmatisation and a "culture of silence" surrounding mental health issues (Moll, 2014; Moll *et al.*, 2013). Other studies suggest that attitudes regarding working alongside someone with a mental illness are improving; employers surveyed in 2010 were less likely to say that workers with mental health problems faced negative attitudes from their colleagues compared to in 2006 and 2009 (Henderson *et al.*, 2013). However negative attitudes appear to considerably affect the way those with mental illness are treated in the workplace (Corker *et al.*, 2013). It has been shown that those with mental illness experience being looked down on and treated as if they had low intelligence (Brohan *et al.*, 2014).

Thus, whilst most employers would prefer disclosure of a mental health condition during the application process (Little *et al.*, 2011), there are reasons why employees prefer not to disclose. However, disclosure allows the person access to support and reasonable adjustments under the Equality Act that could assist them in maintaining performance. Employees may also receive emotional support from colleagues; a common reason for disclosing (Brohan *et al.*, 2012). It has been shown that a large number of different social, psychosocial and demographic factors affect the decision to disclose (Corrigan *et al.*, 2015b). The GMC (General Medical Council) states that disclosure to managers and occupational health is mandatory if there is a risk that a health professional's illness could pose a risk to patients (General Medical Council, 2013). The aim of this study was to explore experiences of disclosure and attitudes within the NHS towards colleagues with mental illness, with the goal of informing the NHS in developing effective programmes, policies, or interventions to reduce workplace stigma and support employees with mental illness.

Method

This was a qualitative study using semi-structured interviews with health care professionals employed by an NHS trust. An NHS trust is an organisation that provides healthcare to a specific area. The trust from which we sampled provides community based physical and mental health care to people

living in three local government areas in London. The areas include a wide range of socioeconomic conditions, from relatively deprived to affluent areas, both urban and suburban.

This project was approved by the King's College London Research Ethics Committee (Ethics number: PNM/11/12-118). Research and Development approval was obtained from the NHS trust. The study was conducted using Berg's guidelines to qualitative research (Berg *et al.*, 2004).

Interview participants were recruited from respondents to an electronic survey exploring attitudes towards mental illness and disclosure amongst NHS staff in participating NHS Trusts (Sherring *et al.*, unpublished). The survey included an invitation to participate in telephone interviews and participants were asked to provide contact details. One NHS trust was selected for the qualitative study because it provides both mental health and general health services—this was felt to be a good representation as most NHS trusts employ a mix of these two groups. Of the 261 respondents, 119 consented to being interviewed. Participants were divided into those that worked in mental health and those that did not, as these two groups differ in their attitudes towards mental illness (Henderson *et al.*, 2014b). Maximum variation sampling was undertaken to select a diverse range of participants to gain insight into meaningful differences in experiences (King & Horrocks, 2010), using characteristics such as age, gender, and job role. Participants were contacted using the email address they had provided and telephone interview appointments were arranged. Participants were contacted until data saturation was reached, defined as the point at which no new information or themes are observed in the data (Guest *et al.*, 2006). In total 24 people were interviewed; 13 mental health professionals and 11 non-mental health professionals.

A semi-structured interview guide was developed (Bryman, 2004), piloted on a former nurse independent of the research study and then revised. Questions focused on participants' experiences of working with someone with a disclosed mental illness, the support available, disclosure (their own or a co-worker's) or their feelings towards a hypothetical disclosure. Participants were asked to ensure they were in a place where they could speak openly. Interviews were conducted by one of two researchers (W.W. and C.L.) and recorded with the permission of the interviewee, then anonymised and transcribed by the researchers. After transcription the recording was erased.

Data analysis was concurrent with collection to determine when saturation was achieved, providing an economical way to sample (Fox & Hadar, 2006). Thematic analysis was performed (Braun & Clarke, 2006) using combined inductive and deductive approach to obtain themes from the data (Greg *et al.*, 2012), simultaneously generating and reviewing themes. (Note: Analysis does not include a quantitative analysis of the topics).

Initial coding was open, descriptive and data driven, conducted line by line. Each researcher (CL and WW) initially coded three transcripts, then applied these codes to the next three transcripts, repeating until all transcripts were coded. The codes were amalgamated by the researchers and a coding manual was formed, which was given to another researcher and applied to three transcripts to improve reliability. Later analysis was more latent, coding by unit of

Table 1. Demographic characteristics of participants.

	Mental health professionals	Non-mental health professionals
Sex		
Male	7	1
Female	6	10
Age		
18–30	2	1
31–40	3	1
41–50	5	6
51–60	3	3
Ethnicity		
White-British	7	8
White-American	0	1
White-Irish	2	0
White-other	1	0
Asian British-Pakastani	0	1
Black British-African	3	1
Job role		
Nurse	13	6
Occupational therapist	0	1
Therapy assistant practitioner	0	1
Physiotherapist	0	1
Health care assistant	0	1
Speech and language therapist	0	1

meaning and examining underlying themes. Themes were reviewed by both researchers, and it was found that many overlapped and could be combined to give a manageable short list, allowing the themes to be defined.

Results

The following description of themes combines and summarises answers from both groups interviewed. Participants' demographic data is shown in Table 1. Themes are shown in Table 2: there was a large degree of overlap with only one unique theme.

Personal experiences and their effect in changing attitudes

Participants described a range of experiences with mental illness. All participants described a change in their attitudes resulting from their experiences, often those concerning family or friends. Such experiences increased awareness and understanding of the struggles facing those with mental illness:

I've actually got a daughter with a mental health problem and I suppose my views have changed since she was diagnosed, I see it from a different angle and how it affects people and how it affects people in families and I think I'm probably more empathetic now... (NMH, Female, 50)

These experiences can lead people to change their views about who is susceptible to mental illness, dispelling ideas that only certain people suffer from mental illness:

... typically a mental health person you'd think, you know somebody that's loony, doesn't know what they're doing but obviously I know that my colleague was quite capable of doing her normal daily job... everybody thinks they look a certain way, act a certain way but it could be anybody really... (NMH, Female, 33)

Table 2. List of themes.

Overlapping themes	Themes unique to non-mental health staff
Personal experiences and their effect in changing attitudes	Mental illness is not talked about
Perceived stigmatising views of mental illness in other staff members	
Hypothetical disclosure: factors affecting one's decision	
Attitudes towards disclosure	
Support in the workplace after disclosure	

Among non-mental health professionals these experiences made them aware that mental illness was more widespread than they first thought and can affect their colleagues:

Well the way it influences my opinion on mental health that it's just... far more widespread than we understand it to be in the workplace... I think we need to acknowledge the fact that there will be colleagues that we are actually working with being affected. (NMH, Female, 41)

Mental health professionals commonly mentioned how their training and experience of working in mental health care had made their views more positive:

When I was much younger my view was very negative... Now that I work in mental health I've got a much more positive view. [Mental health professional (MH), Male, 26]

Almost all participants were able to recall a colleague who suffered from mental illness whether they had suspected or it had been disclosed. Many such colleagues were not affected in terms of their ability to do their job:

... she was very flat in terms of how she was feeling and she was having relationship trouble, it didn't affect her ability to do her job role at all. (NMH, Female, 41)

However, participants described a few colleagues whose ability to do their job was affected:

... she was doing some very odd things that might have been dangerous. (NMH, Female, 46)

Perceived stigmatising views of mental illness in other staff members

Both professional groups highlighted the perceived divide between people with mental illness and themselves:

... for staff as well sometimes when it comes to their colleagues, they think 'not me, that wouldn't happen to me' and it does. (MH, Female, 38)

Every participant conceded that mental illness is stigmatised a common view was that colleagues would react more sympathetically to those with a physical illness:

... it certainly does carry stigma, and in general yeah in general it would carry more stigma than physical illness yeah. (MH, Male, 27)

The difference was attributed to their own previously negative attitudes, and to lack of understanding; when understanding increased, this helped to form positive attitudes. Personal cultural background was referred to when this was non-western. One participant from an African background stated:

I grew up with the stigma that mentally ill patients ‘they are dirty’... ‘you can’t associate with them’. (MH, Female, 43)

Among mental health professionals there was a view that levels of stigmatisation had improved over time, and that in mental health care the attitudes were significantly less stigmatising than other areas of healthcare:

I worked in psychiatric nursing and there I think that stigma is gone, but I think with other nursing fields... within general nursing I think there may be some old fashioned attitudes still there. (MH, Male, 52)

Non-mental health professionals described negative attitudes held by colleagues. This was attributed to colleagues not understanding the difference between stress and mental illness, or not viewing mental illness as a proper illness:

...I’ve heard people saying oh well you know we’re all stressed, they don’t actually realise that it is actually an illness as such it’s not just the normal day to day stress. (NMH, Female, 51)

Hence participants described non-mental health professionals as questioning people taking time off for what they perceive as everyday stress:

... there are some people who repeatedly are off sick with stress, I’m sure completely validly, but I wonder whether people do think, maybe some people doubt whether that’s entirely needed... (NMH, Female, 25)

Despite reports that some colleagues had negative views, all participants stated that their own attitudes to mental illness were positive.

Hypothetical disclosure: factors affecting one’s decision

On the whole participants deliberated carefully about whether they would disclose a mental illness. Among the factors identified that would affect whether they would choose to

disclose, the commonest was the importance of trust and the perceived supportiveness of one’s manager:

I wouldn’t necessarily, unless they had a supportive manager, I think that’s how it comes down to. I mean I’m sure there’s a lot of policies in place in every NHS organization about how to support staff but the bottom line is how you get on with your manager... they might treat you differently. (NMH, Female, 41)

Whether illness was affecting their ability to do their job was the second important factor identified as influencing disclosure. Participants identified circumstances where disclosure was an obligation:

... if I don’t feel well in myself then I would be worried about my clinical practice so I feel it would be my duty to come forward. (MH, Female, 41)

Attitudes towards disclosure

Risks of disclosure included the possible effects of disclosing on one’s career, for example losing their job or being passed over for promotion:

I think yes there is a risk that if you disclose you might not be able to progress maybe as quickly as others who might not be suffering from mental illness. (MH, Female, 43)

A separate and important concern was colleagues’ reactions after disclosure. Participants described a stigma surrounding mental illness in the workplace to which they would be exposed:

I think there’s a huge amount of stigma, the majority of staff look dubiously on people who have disclosed that they’ve got a mental health illness. (NMH, Female, 46)

Some theorised about why this was:

... the idea that maybe you’re seen as weak and not able to cope. (MH, Male, 27)

All participants noted that health professionals were expected to ‘get on with it’. Mental health practitioners indicated a pressure specific to their role:

... as mental health professionals we tend to feel that we need to put on a bit of a brave face. (MH, Male, 37)

Only one participant identified the effort of the process of disclosure may put colleagues off:

my closest friend was a nurse... and went for a new job and didn’t disclose at all which I thought was, I couldn’t imagine doing that but she just said she couldn’t deal with all the hoops she’d have to deal with to kind of disclose it. (NMH, Female, 41)

Identified advantages to disclosure included the support from colleagues:

... if people have the courage to come forward and say 'I have these struggles and my family have had struggles' then I do think you get support. (MH, Female, 41)

Similarly, the idea that colleagues would be more understanding were they aware that there was an underlying issue:

I was struggling at work so I think it was important for people to understand that I was having a hard time... I didn't want people to think oh it's just she's being lazy or she's just being this or being a bit dramatic, that there was actually an underlying issue as to why I was struggling. (NMH, Female, 43)

A further advantage identified was support such as counselling and reasonable adjustments as an advantage of disclosure:

With work things can easily spiral out of control and you're not gonna receive kind of the support you need whether that be time off or adjustments made at work if you're not honest and upfront about it with people who can support you. (NMH, Female, 25)

Support in the workplace after disclosure

Whilst describing personal experiences or experiences with a colleague with mental illness, managers were generally described as having been helpful and supportive:

... My manager was really, really good and very supportive... she was happy to support her for however long she wanted which was really really good. (NMH, Female, 33)

Current examples of workplace support were also provided:

We're trying to make reasonable adjustments so that the person can come back to work and hopefully remain working in this service. (MH, Male, 52)

However, there was a discrepant view of managers as unsupportive:

They don't even come out on the floor to see what's happening, you know ... We are not being supported, the only support we can get is through the GP. (NMH, Male, 59)

Similarly, it was acknowledged that levels of support may differ depending on the employer:

... certainly access to occupational health, to counselling services, to peer support networks as well for people with lived experience. So that's in my current trust; in my previous trust I think you might have been able to get an

occupational health referral but I'm not quite sure how much more support there was. (MH, Male, 37)

One issue only raised by mental health professionals was that receiving treatment for mental illness had the potential to place them under the care of colleagues:

... she knew a member of the team that had worked in another borough, he'd nursed her, so that was awkward. It was tricky. (MH, Female, 57)

Mental illness is not talked about

A theme unique to non-mental health professionals was that mental illness was not talked about in the workplace. The main reason appeared to be that people felt uncomfortable talking about it:

... just I think that a lot of people that I work with do or have had some experiences but people don't always like to talk about it. (NMH, Female, 52)

This was felt to result in isolation of those with mental illness and lack of awareness of their needs:

In that sense there's obviously a lot of isolation already when somebody has a mental health problem and that's kind of compounded by that kind of isolation I guess er because people don't know what to say and how to talk about it... and because of mental health being not talked about, there isn't that same awareness of what people need. (NMH, Female, 41)

Discussion

Participants described a range of experiences with mental illness both inside and outside of work. These first-hand experiences of mental illness profoundly affected their attitudes; consistent with previous literature (Corrigan et al., 2001). The development of more positive attitudes after these experiences is consistent with the intergroup contact hypothesis (Allport, 1954) for which there is strong empirical support (Al Ramiah & Hewstone, 2013). Similarly, personal contact with mental illness has consistently been associated with improved attitudes among the public (Evans-Lacko et al., 2013). This may explain why increased availability of information alone does not improve public attitudes (Schomerus et al., 2012).

The positive impact of training for mental health professionals has been previously described in literature (Couture & Penn, 2003; Nordt et al., 2006). However, there is also evidence that at least some aspects of mental health professionals' attitudes are more negative than those of the general public, e.g. therapeutic pessimism (Jorm et al., 1999).

Every participant believed that mental illness holds a stigma—consistent with research revealing that the majority of psychiatric patients feel stigmatised (Corker et al., 2016). Whilst some mental health professionals felt that stigmatisation was less prevalent in mental health care, non-mental

health professionals reported that it was common for colleagues to have negative attitudes, some mentioning that mental illness is not seen as a “proper” illness. During interviews some participants stated that they had a diagnosed mental illness and it was apparent that many participants with a mental illness fear stigmatisation and discrimination from their colleagues, demonstrating that health professionals are not immune to stigmatisation in the workplace. Further, this fear may be a significant factor in preventing disclosure [as it is in other workplaces (Brohan et al., 2012)].

While there was evidence of good practice on the part of managers this was not universal. This study supports the finding that the role of the manager is particularly important in disclosure decisions (Brohan et al., 2014; Evans-Lacko & Knapp, 2014) as the supportiveness of the manager was identified as one of the most important factors affecting a hypothetical disclosure. Similarly, the degree to which one’s mental illness affects one’s work has previously been found to be an important factor in deciding whether to disclose. Ellison et al (Ellison et al., 2003) found that those who displayed no symptoms at work were less likely to disclose. This factor may be particularly important for health care professionals due to the importance of safe, adequate patient care and encouragement to raise concerns about other’s practice.

Advantages to disclosure identified by participants are consistent with literature, namely increased understanding from colleagues (Brohan et al., 2012), and support (MacDonald-Wilson, 2005).

Concerns about stigmatisation and discrimination in the workplace have been highlighted in previous research (Brohan et al., 2012). Specifically, there was concern about losing one’s job or not getting promoted, both of which have been demonstrated in previous studies (Ellison et al., 2010). However, participants were also concerned about being seen as unable to cope, in particular mental health professionals described wanting to put on a brave face and not let the team down. Many minimised the impact that the stress of their job was having, reasoning that everyone was under the same stress.

Strengths and limitations

In common with all qualitative work, we cannot determine the representativeness of our sample. However, a strength of our sampling method was that we recruited from a trust providing both mental health and other community health services. This allowed us to include both mental and general health professionals, as well as by chance a couple of participants who had experience of working in both mental and general health fields. Validity could be compromised if respondents did not answer questions honestly. Strategies including allowing respondents to choose not to be recorded (although no participants declined to be recorded) and reassuring them that their data would remain anonymous were employed to reduce participants’ need to give socially desirable answers. Nevertheless, it was clearly easier for participants to discuss their negative attitudes as they existed in the past, and the current negative attitudes of colleagues, as opposed to their current negative attitudes. As social desirability can affect stigma questionnaire responses especially when delivered face

to face (Henderson et al., 2014a), this is likely to apply to individual in depth interviews on attitudes to mental illness.

Implications for future research

This was a small-scale explorative qualitative study. Larger, quantitative studies are needed to determine the generalisability of these findings. As attitudes have been shown to change over time due to experiences, a longitudinal approach may be valuable in future. Interventions are needed to create an environment in which employees feel able to disclose. This study suggests an intervention involving training for managers would aid health professionals with mental illness as managerial supportiveness has been shown to be vital in disclosure decisions. At the organisational level, leadership is needed to enable managers to provide such support. Critically, organisations must explicitly value and promote recruitment of professionals with lived experience of a mental health problem.

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Declaration of interest

No potential conflict of interest was reported by the authors.

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